Discretionary Funding

Questions presented to the regional councils for further discussion and feedback: If discretionary funding or a percentage of discretionary funding were set aside for regional councils to submit proposals as part of their funding plans for consideration by the Board for areas such as capacity building, research, and innovation, cross regional coordination, public/private partnerships, taking a strategy or set of strategies to scale, what are your reactions to this? What are the considerations and implications of this? What other considerations do you want to put on the table for discussion around discretionary funding?

Below is a summary of the feedback compiled by the regional councils regarding the discretionary funding. Overall, the feedback reflects that the regional councils prefer that the methods currently used to allocate the discretionary funding remain in place at this time. Regional Councils did identify ideas for how the discretionary funding could be allocated differently and provided criteria and considerations for those ideas. In addition, there is support for an ad hoc committee to be convened to further review and provide recommendations to the Board.

Major reasons identified for not changing the way discretionary funding is allocated

- It is too soon to determine how best to allocate discretionary funding:
  - Need much more information about the ramifications of each possible option and how that would impact the regions;
  - A few more years would give regional councils the ability to determine which strategies and/or approaches best fit with this type of funding.

- Current method of allocating the discretionary funding is fair, equitable and working:
  - Comfortable with the way they are currently allocated;
  - Overall, the consensus was to keep it equitable and "as is";
  - The current formula works well and equally distributes funds to regions;
  - Likes the idea of using some of the discretionary funds for Capacity building, research and innovation, cross regional coordination, public/private partnerships and/or taking strategies to scale, however the discretionary funds used for these ideas should remain at the current regional level (calculated at the regional level using population and poverty data);
  - Appreciate the spirit of collaboration and coordination that is occurring cross-regionally and is helping to maximize funds and support neighboring regional councils that may not have the funds.

- A change to the discretionary funding would be a significant concern to the rural regions:
  - Rural Regions need to have the Frontier Adjustment as the funds are built into the funding plan to sustain strategies;
  - The Frontier Adjustment allows rural regions to address the higher cost associated with hiring and retaining qualified staff, the cost of travel necessary to implement work in the region, and be able to have the funding necessary to support the capacity building and infrastructure development needs that exist;
  - Rural regions face many challenges in implementing strategies such as geographic challenges of remoteness, transportation, and the great need that children and families have for support and resources across large geographic areas;

- Discretionary funding has supported rural areas in building capacity and bringing programs to scale. Discretionary funds constitute a third of the allotment and the loss of these funds could impact the ability to build capacity and to bring programs to scale in rural areas.

- A change in the discretionary funding could significantly impact a region's allocation and ability to address needs of the region:
  - The Council is very concerned that if our funding amounts go down in any way we will have extreme problems in maintaining any type of a system in the area;
  - If our discretionary funding is no longer provided to the regional council, it will reduce the size of our budget tremendously, by about one third;
  - This will impact the number of children we will be able to serve;
  - Rural regions require more funds to effectively build capacity and provide services to rural children;
  - Concerned about a reduction or complete removal of discretionary funding from the allotment. Discretionary funding comprises about a third of the base allocation and they feel that the potential loss of a third of the annual budget would have a negative effect on their ability to provide services and resources to children and families as they move forward.

- There is a concern about putting in place a competitive process:
  - A competitive process will favor regions with more capacity and perpetuate a "haves" and "have-nots" situation;
  - Competitive grants would place smaller regions at a disadvantage. These regions don't have the capacity that larger regions do to write grants and to use existing regional capacity for new projects;
  - Unintended consequences may arise with the approval of a proposal/application process, such as:
    - Other regional councils that have proposals that are unfunded feeling animosity towards those that have proposals approved;
    - Capacity of regional councils may vary in the area of developing proposals.

- Some level of concern that this is a punitive action for regional council's that have not spent funds:
  - There was an analogy about "discretionary funding" is a reward for those regions that are able to spend funds more easily because they don't have capacity or scalability issues;
  - It was acknowledged that if there are regions that continue to maintain large carry forward balances that it does present challenges, especially as there are most likely other regions that do have the ability to more fully utilize funding. So while there is an understanding for the need and desire to utilize funds to the fullest and most efficient and effective extent possible, there are concerns about the potential loss of funds in their region;
  - There is a feeling that "if we don't spend it, we won't get it".....this may lead to unwise planning decisions on the part of regional councils so that they can maintain their overall budgets.

- Additional comments:
  - There is no fair way to rework the distribution of discretionary funds that could not be challenged;
  - Though the regional council was not loudly in favor, they are willing to entertain a shift in the way these funds are distributed, bearing in mind there is always initial resistance to change, even if the change produces an improved outcome.

Concepts on how discretionary funding could be re-allocated

- Continue to use the current funding formula but for the Board to consider establishing categories or themes for how discretionary monies can be used. The amount that needs to be allocated to a category or theme should increase gradually. If a region includes one or more of the themes in their funding plan then the region receives the funding.
  Examples:
  - Funds used for specific goal areas such as Quality First; To develop/improve the services for children with identified special needs who don't qualify for AzEIP;
  - Evaluation;
  - Funds for regional council's benchmarks being evaluated;
  - Taking priority strategies to scale.

- Consider discretionary dollars to be used to promote coordination within regions, cross regionally and for neighboring tribes to develop strategies together. The structure/process would be governed by all the chairs of First Things First regions included in the collaborative effort and decisions would be based on what is in the best interest of the entire cross regional area rather than a single region.

- Invest in Public Private Partnerships: Consider using the discretionary money for matching funding as various grants require some sort of matching of funds which would be a great use for discretionary dollars; FTF funds could be used to leverage other public private partnerships.

- Consider Funding Innovation and Research at a local level. There are various examples of that include professional development, dual language learners, etc.

- Using discretionary funding for one time needs or short term needs. Use as part of a systems building mechanism as long as it is going to achieve what is sustainable and systematic. If one time funding for a project becomes an option, what has to be looked at is the future impact and how this will advance the system; Setting aside a lesser amount of discretionary dollars for working on systems-building may be favorable option though a small pot of funds should be considered.

- Takes a small portion of the pot and makes it competitive:
  - Reluctant to see competition between regional councils because there can be winners and losers which can cause animosity between the regional councils;
  - Consider having rural regions earn extra 'points' or somehow be given additional weight so that the field is still somewhat level when proposals are reviewed for funding decisions. There is concern that proposals from rural regions would not be viewed in the same light as proposals from larger urban regions as a function of the overall cost to conduct the work – the more children there are, the more the work would likely cost, and with limited funding to go around, the fear is that rural regions would lose out because the numbers that might be impacted would likely be smaller;
  - Criteria identified:
    - Consideration should be given to who will carry out work and how a proposed program will be implemented if regional council drafts a proposal to be awarded funds;
    - Ensure that a sufficient amount of financial resources are distributed to see impact;
    - Equitable practices in how funding is issued need to be put in place;
    - Continue this approach for at least three years.

- Expand Frontier Adjustment
    - Consider using discretionary funds primarily in rural areas (due to considerations about urban areas having more funds for strategies);
    - Allocate funds to tribal regions to counter-balance the low census counts;
    - Consider adding to the "Frontier" formula the extended rural areas of Southwest Maricopa, for example Gila Bend. Towns in Southwest Maricopa do receive extra federal funding considerations for their location and the fact that other adjacent rural areas are being served by these center towns, i.e. Sentinel, Paloma, Dateland.

- Allocate funds to build capacity in rural areas, for prioritized goal areas, to address barriers that are impeding the implementation of new programs.

- Develop guidelines on how discretionary funding can be most effectively utilized, i.e., provide a distinction between "long-term" base funding and more "temporary funding".

Forming an ad hoc committee

- There is broad support to form an ad hoc committee to review the feedback from regional councils on discretionary funding and provide a recommendation on how to proceed, taking into account the various perspectives from all of the regional councils, to the Board.
    - Would like to see a group of representatives from regional councils across the state that is representatives of urban, rural and tribal regions and the flexibility to participate via live meeting or conference calls.

Should changes be made, considerations for how to roll this out

- Any changes to current the funding formula should be presented to regional councils well before any changes are made.
- If the Board does change the funding formula – please do not do it all at once - don't take discretionary dollars all at one time.
- Board needs to phase in whatever process it decides.
- If changes that could have significant impact on regional funding should be made in the future, it would be important that they be made in alignment with the three year funding plan cycle.

Questions Raised

- Have we explored what other states have done?

FIRST THINGS FIRST

Ready for School. Set for Life.

School Readiness Indicators

Regional Benchmarking for the School Readiness Indicators

Achieving the mission of First Things First to ensure all young children arrive in kindergarten healthy and ready to succeed will require more than simply funding programs and services. It will take all partners, across the state, to own a common vision for children in Arizona and a cross-sector commitment to ensure that vision is realized.

First Things First School Readiness Indicators were chosen to reflect the effectiveness of funding strategies and collaborations built across communities to improve the lives of children residing in the state of Arizona and improve their readiness for entering school and subsequently their life long success.

In April 2014, Regional Partnership Councils will recommend 2020 benchmarks for prioritized indicators to the First Things First Board. To support those discussions and the community forums that follow, the data release phases below have been set.

A phased approach was selected due to data availability as well as considerations for how to provide technical assistance for decision-making. Data releases will include a one-to-two page fact sheet for each indicator selected by the Regional Council which provides regional-specific data for decision-making on benchmarks for those School Readiness Indicators prioritized. Prior to Phase I, a series of three webinars will be available in March 2013 and will include: 1) overview of the School Readiness Indicators, recap of the selection of data sources, and description of the state-level benchmarks; 2) background and assistance on interpreting tribal data; and 3) guidance in how to set benchmarks, including data interpretation and assistance on setting attainable yet aspirational goals. Additional support materials, as well as discussion and decision-making facilitation, will be provided throughout the process.

Data Release Phases

Phase 1: April - June, 2013

Non-Tribal Regions - **Indicator 6**: #/% of children entering kindergarten exiting preschool special education to regular education

Non-Tribal Regions - **Indicator 7**: #/% of children ages 2-4 at a healthy weight (Body Mass Index-BMI)

Phase 2: June – August, 2013

Tribal Regions - **Indicator 6**: #/% of children entering kindergarten exiting preschool special education to regular education

Tribal Regions - **Indicator 7**: #/% of children ages 2-4 at a healthy weight (Body Mass Index-BMI)

Tribal Regions - Indicator 8: #/% of children receiving at least six well-child visits within the first 15 months of life

Tribal Regions - Indicator 9: #/% of children age 5 with untreated tooth decay

Phase 3: August – October, 2013

All Regions – Indicator 2: #/% of children enrolled in an early care and education program with a Quality First rating of 3-5 stars

All Regions – Indicator 3: #/% of children with special needs/rights enrolled in an inclusive early care and education program with a Quality First rating of 3-5 stars

All Regions – Indicator 4: #/% of families that spend no more than 10% of the regional median family income on quality care and education with a Quality First rating of 3-5 stars

Non- Tribal Regions - Indicator 8: #/% of children receiving at least six well-child visits within the first 15 months of life

Non- Tribal Regions – Indicator 10: % of families who report they are competent and confident about their ability to support their child's safety, health and well being

Phase 4: September – October 2014

Tribal Regions – Indicator 10: % of families who report they are competent and confident about their ability to support their child's safety, health and well being

Phase 5: TBD

All Regions - Indicator 1: #/% children demonstrating school readiness at kindergarten entry in the development domains of social-emotional, language and literacy, cognitive, and motor and physical

All Regions – Indicator 5: % of children with newly identified developmental delays during the kindergarten year

Non-Tribal Regions – Indicator 9: #/% of children age 5 with untreated tooth decay

School Readiness Indicators
Benchmark Data Sources

Indicator #1:	**#/% children demonstrating school readiness at kindergarten entry in the development domains of social-emotional, language and literacy, cognitive, and motor and physical**
Intent:	Increase the number of children with equal opportunity to be successful in school and close the achievement gap before kindergarten entry

Benchmark Data Source:
There is currently no data on school readiness at kindergarten entry available at the statewide level in Arizona. Considerations were given to possible use of public school district or school site level data, but data availability is not consistent, as districts or schools determine whether any data is collected. Additionally, if school readiness is assessed, an inconsistent variety of instruments and processes are used.

The Arizona Department of Education (ADE), First Things First, the State Board of Education, and Virginia G. Piper Charitable Trust are working together to develop an Arizona kindergarten developmental inventory instrument that is appropriate for all Arizona children to be administered at the beginning of the kindergarten year to measure areas of school readiness. Representatives from these agencies have agreed on the following purpose statement:

> To provide a kindergarten developmental inventory tool that allows parents, teachers and administrators to understand the extent of a child's learning and development at the beginning of kindergarten to provide instruction that will lead to the child's academic success. The tool that is developed or adopted will align with the *Arizona Early Learning Standards* and *Arizona's Common Core Standards* for kindergarten, cover all essential domains of school readiness (physical and motor development, social and emotional development, approaches to learning, language development and cognitive development) and will be reliable and valid for its intended use.

The agencies are also participating in national conversations that originated in the Race to the Top – Early Learning Challenge grant application process to determine how other states are developing measures of school readiness at kindergarten entry. Public input will also be solicited and considered in making final recommendations and decisions on the Arizona process and age-appropriate tool used for the kindergarten developmental inventory.

After analysis of data collected using the approved instrument, data will be available at the regional level.

Indicator #2:	**#/% of children enrolled in an early care and education program with a Quality First rating of 3-5 stars**
Intent:	Increase the number of children with access to affordable high quality early learning programs

Indicator #3:	**#/% of children with special needs/rights enrolled in an inclusive early care and education program with a Quality First rating of 3-5 stars**
Intent:	Increase in the number of children with special needs/rights who enroll in high quality inclusive regulated early learning programs

Indicator #4:	**#/% of families that spend no more than 10% of the regional median family income on quality care and education with a Quality First rating of 3-5 stars**
Intent:	Increase the number of families that can afford high-quality early learning programs so family financial contribution is no higher than 10% of the regional median family income

Benchmark Data Source:
All three indicators depend on the Quality First star rating to report progress, so the Quality First Data System administered by FTF was identified as the best data source for these indicators, as it will contain all updated enrolled providers' star rating, as well as information on number of children and number of children with special needs/rights enrolled. Information on families, including household income, will also be integrated from the Quality First Scholarship program. Other potential data sources considered were the Child Care Resource and Referral (CCR&R) database, the Head Start Program Information Report and the Market Rate Survey conducted every two years by the Department of Economic Security. However, these sources do not directly contain the Quality First star rating information needed to measure progress on these indicators.

Indicator #2: Quality First ratings began on July 1, 2012, and continue throughout the year. FTF anticipates that enough Quality First participating providers will complete the rating process by July 1, 2013, so that regional data may be initially analyzed to determine a benchmark for this indicator.

Indicator #3: The Quality First provider profile, part of the Quality First Data System, will be updated by July 1, 2013 so that all participating providers will submit information on the number of children with special needs/rights enrolled in their program. Children with special needs/rights are defined by those children with an Individual Family Service Plan (IFSP), an Individual Education Program (IEP) or a 504 Plan. The IFSP (birth to age 3) and IEP (age 3 to 5) are plans for special services for young children with developmental delays and are required for children meeting eligibility requirements under the Individuals with Disabilities Education Act. A 504 plan refers to Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA), and spells out the modifications and accommodations that will be needed for a child to have an opportunity to perform at the same level as their peers, and might include such things as wheelchair ramps, blood sugar monitoring, or a peanut-free eating environment.

Indicator #4: Data housed in the Quality First Data System related to Quality First Scholarship usage will be used to identify how much families are currently paying for quality early care and education with a Quality First rating of 3-5 stars. Quality First participating providers will complete the rating process by July 1, 2013, and data from families receiving Quality First Scholarships will be initially analyzed to determine a benchmark for this indicator.

Data for these indicators will be available at the regional level for all regions funding Quality First.

Indicator #5:	**% of children with newly identified developmental delays during the kindergarten year**
Intent:	Increase the number of children who are screened and if appropriate, receive a diagnosis and early intervention services for developmental delays prior to entering kindergarten

Benchmark Data Source:
A data source has not yet been selected to determine state level or regional level benchmarks. There were several data sources considered, including:

- Arizona Early Intervention Program (AzEIP): AzEIP provides screening, evaluation and intervention services for children birth to age three, and therefore does not collect data on children who are in kindergarten.
- Arizona Health Care Cost Containment System (AHCCCS): AHCCCS does have information on kindergarten age children; however, does not have a standardized data collection on newly identified developmental delays during the kindergarten year.
- First Things First Developmental Screening Grantee data: FTF grantees provide developmental *screening* for children birth to age five, but do not provide the actual diagnosis of a developmental delay. Also, FTF grantees do not provide services to children in kindergarten.
- Arizona Department of Education (ADE): ADE collects data from school public school districts, and with some modification to the data requirements, it is possible that this type of data could be collected by ADE so that FTF could measure progress on this indicator.

After significant discussion among policy experts and stakeholders, the general consensus was that the indicator language as written would not be the most effective measure of how many children are receiving screening and, if appropriate, intervention services in the years prior to kindergarten. Educators also shared that fewer children are being diagnosed with developmental delays during the kindergarten year, because educators are likely to try other supports before officially identifying children as developmentally delayed.

Concurrent to the discussions about the language for this indicator and data on early intervention, First Things First and St. Luke's Health Initiative partnered together to commission a comprehensive statewide opportunity analysis on the Arizona early intervention system (birth – age 5) with a final report due in July 2013. This project has been vetted with partners in the early intervention system, and the final report will include an assessment and analysis of existing data, which will further inform the discussion about how this indicator is written and the data source and benchmark recommendation at both state and regional levels.

Indicator #6:	**#/% of children entering kindergarten exiting preschool special education to regular education**
Intent:	Increase the number of children who transition to kindergarten without an identified special need due to timely screening, identification and delivery of effective intervention services prior to their kindergarten year

Benchmark Data Source:
Data sources considered for this indicator include:

- Arizona Department of Education (ADE) Individuals with Disabilities Education Act (IDEA) Part B data: ADE collects data annually for this indicator for all IDEA Part B preschool public school special education programs, including those public schools located in tribal communities.
- Tribal Head Start Programs: Head Start data is a potential data source to determine the number of children who received special education services that were not provided in a public school setting.
- Bureau of Indian Education (BIE) Family and Child Education Programs (FACE): The FACE program supports parents as their child's primary teacher and also promotes the early identification and services for children with special needs, so is a potential data source of children who received special education services that are not funded through IDEA Part B.

The ADE IDEA Part B preschool data that is collected annually was determined to be the best data source for this indicator, since the data is already available in an ADE administrative database. FTF will work individually with those tribal regions where a public school district is not located to determine the best data source for this indicator (Head Start, FACE program or other).

Data for this indicator is available at the school district or county level.

Indicator #7:	#/% of children age 2-4 at a healthy weight (Body Mass Index-BMI)
Intent:	Increase the number of children who maintain a healthy body weight

Benchmark Data Source:
Body Mass Index (BMI) is a measure used to determine childhood overweight and obesity. It is calculated using a child's weight and height. Two primary sources of Body Mass Index (BMI) data were considered for this indicator:

- Arizona Women, Infants and Children (WIC) Nutrition Program data: WIC is a federally funded program providing residents with nutritious foods, nutrition education, and referrals. WIC serves pregnant, breastfeeding, and postpartum women, and infants and children under age five who are at nutritional risk and who are at or below 185 percent of the federal poverty guidelines. This program measures BMI of all enrolled 2-4 yr. old participants for all regions of the state. WIC data is available for non-tribal regions and the Navajo Nation Regional Council (with tribal permissions) through the Arizona Department of Health Services (DHS). Data for tribal regions is available (pending tribal permissions) through the Intertribal Council of Arizona (ITCA) or tribal authorities. WIC serves a very large number of low-income 2-4 year olds and their families in Arizona; however, it does not measure the BMI of all Arizona children, only those enrolled in the WIC program. Some regions may be better represented by WIC data than others. Specifically, those communities with large percentages of the population at or below 185 percent of the federal poverty guidelines will have better measurement with the WIC data.
- Arizona Health Care Cost Containment System (AHCCCS): The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid agency that offers health care programs to serve Arizona residents. Individuals must meet certain income and other requirements to obtain services. Data is collected through AHCCCS for all participants, but this data is not currently available in a standardized report, and access to the data requires permission from AHCCCS.

There currently is no data source that measures the BMI of all Arizona children. However, WIC data from DHS and ITCA (pending tribal permissions) was identified as best data source for this indicator because consistent data are available for all regions and the WIC program serves a large number of Arizona 2-4 yr. olds (105,968 in the initial data pull).

Data for this indicator is available at the regional level.

Indicator #8:	**#/% of children receiving at least six well child visits within the first 15 months of life**
Intent:	Increase the number of children with consistent well child visits where there is higher opportunity for immunizations, appropriate screenings and early identification of development delays, other medical healthcare, and support for family members to understand their child's health

Benchmark Data Source: There were two primary sources of data considered for the measurement of regular well child visits:

- Arizona Health Survey: The Arizona Health Survey is a large-scale phone survey that has been conducted by St. Luke's Health Initiatives to provide data on Arizonans' healthy behaviors, health care, and health insurance. Data from this survey identifies, through parent report, whether a young child has been to a physician for a routine visit in the past year. The Arizona Health Survey provides data on families throughout Arizona with a representative sample of phone surveys.
- Arizona Health Care Cost Containment System (AHCCCS) and Indian Health Service (IHS): AHCCCS is Arizona's Medicaid agency that offers health care programs to serve Arizona residents. The Indian Health Service (IHS) is an agency within the Department of Health and Human Services and is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. The IHS is the principal federal health care provider and health advocate for Indian people and provides a comprehensive health service delivery system for American Indians and Alaska Natives who are members of 566 federally recognized Tribes across the U.S.

  Both AHCCCS and IHS utilize performance measures developed and maintained by the National Committee for Quality Assurance (NCQA), called HEDIS (Healthcare Effectiveness and Information Data Set) or similar measures. HEDIS is the most widely used set of performance measures in the managed health care industry and serves to measure the timeliness and completeness of medical care. There are numerous benefits of utilizing administrative data related to actual well child visits as the data source for this indicator. First, these data are not reported by a parent in a phone survey, they are actual medical records; therefore, errors due to recall are less likely. In addition, while data do not provide information on all children in the state of Arizona, just those served by AHCCCS and IHS, due to the large number of children served in these programs, local data is more likely to be available than through a phone survey.

AHCCCS data for non-tribal regions and IHS data for tribal regions (with tribal permission) were identified as the best data sources for this indicator because data are collected for all FTF regions. FTF is currently in consultation with both AHCCCS and IHS to acquire the data.

Data for this indicator is available at the county or tribal region level.

Indicator #9:	#/% of children age 5 with untreated tooth decay
Intent:	Increase the number of children who begin at an early age and regularly visit an oral health professional to receive preventive oral healthcare and services necessary to treat tooth decay

Benchmark Data Source:

There were three sources of data considered for this indicator:

- Arizona Oral Health Survey: This survey is actually an oral health exam performed by qualified oral health professionals. The Arizona Department of Health Services conducted the survey of preschool children in 1995, and again on almost 1000 preschool children in 2009.
- Indian Health Services (IHS) Oral Health Service Data: This is data collected regularly on oral health services for young children seen through the IHS.
- Arizona Health Survey: The Arizona Health Survey is a large-scale phone survey that has been conducted by St. Luke's Health Initiatives to provide data on Arizonans' healthy behaviors, health care (including dental care) and health insurance. Data from this phone survey identifies, through parent report, whether a young child has been to a dentist for a routine visit in the past year, but does not provide data from actual oral health exams.

The Arizona Oral Health Survey was selected as the data source for non-tribal regions. FTF is partnering with the Arizona Department of Health Services Office of Oral Health to expand the sample size of the Arizona Oral Health Survey to provide data at the county or multi-county level and to complete the survey on a more regular and shorter interval, beginning in 2014-15. Considerations will be made to assure consistent data collection, methods, inclusion of appropriate age groups and consistent protocols.

IHS oral health service data was selected as the data source for tribal regions (pending tribal permissions). FTF is beginning discussions with the IHS to identify appropriate available data and to obtain tribal permissions to use the data for this indicator.

Data for this indicator will be available at the county or multi-county and tribal regional level.

Indicator #10:	**% of families who report they are competent and confident about their ability to support their child's safety, health and well being**
Intent:	Increase the number of families who report they are competent and confident to support their child

Benchmark Data Source:
The Family and Community Survey conducted by FTF was the only data source considered for this indicator. The Family and Community Survey of almost 4000 families is FTF's primary method for gathering consistent data on parent knowledge, skills, and practice related to their young children. This survey was conducted for the first time in 2008 and again in 2012, and will be done every two to three years in the future. In addition to data collected for this indicator, the survey results are also used to inform needs and assets reports and develop FTF communication messages.

Key features of the Family and Community Survey:

- Sampling methodology is designed to obtain a statistically representative random sample of families with children birth to five as well as the general population in each of the First Things First regions (with the exception of tribal regions)
- Statewide and regional samples are designed to reflect current regional and statewide census-based proportions in key demographic categories (i.e. education, socio-economic status, and ethnicity)
- The survey was administered in Spanish or English, based on the preference of the respondent

The survey contains over sixty questions, many of them exploring multiple facets of parenting. Seven of the questions (listed below) are analyzed to arrive at a composite measure of critical parent knowledge, skills and actions for this indicator. First Things First conducted an analysis on several of the relevant survey indicators to arrive at this composite measure.

- % think a parent can begin to significantly impact their child's development brain prenatally or right from birth
- % of parents reported that they or other family members read stories to their child/children seven days a week
- % of parents strongly agreed that their regular medical provider knows their family well and helps them make healthy decision
- % believe that children do not respond to their environment until two months of age or later
- % believe that children sense and react to parents emotions only after they reach seven months of age or older
- % believe that children's capacity to learn may be set at birth
- % believe that a child's language benefits equally from watching TV versus talking to a real person

Non-tribal data are collected through the Family and Community Survey, a phone survey. Best practice indicates that phone surveys are not the optimal method to obtain information for families residing on tribal lands. Data collection on Family and Community Survey items will be integrated into on-the-ground data collection, as part of tribal regional needs and assets reports, beginning in 2013-14 (with tribal approval).

Data for this indicator is available at the regional level.